

Impeding Earl Warren: California's Health Insurance Plan That Wasn't and What Might Have Been

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Abstract It is widely believed that the turning point for U.S. health insurance came in 1949 when Congress failed to adopt President Harry Truman's proposal for a national system. The possibility that a system of state-level health plans might have emerged before Truman's plan has received little attention. Yet several attempts to enact such a plan were made in California by Governor Earl Warren in the mid-1940s. Had Warren succeeded, the California example might have been emulated by other states and the United States might have evolved a system similar to Canada's provincial programs.

State-provided single-payer health insurance is not a topic most people associate with Earl Warren. He is best known as chief justice of the U.S. Supreme Court and for that court's decisions related to school desegregation, legislative apportionment, and defendants' rights. Warren's judicial career has obscured memories of him as the only governor of California to win election to that office three times, once after winning both the Republican and Democratic primary nominations. Few recall Warren as the politician with strong presidential ambitions who ran as the Republicans' vice presidential candidate with Thomas Dewey in 1948. Liberals who admire Warren's record tend to neglect his major role in the internment of the Japanese-origin population during World War II.

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(Mitchell 1999). Conservatives, to whom Warren became anathema, forget or do not know of his origins in the Hoover wing of the Republican Party.

Warren in fact devoted considerable energy as California governor to enactment of a payroll-tax funded single payer health insurance plan for virtually all employees within the state. But because he failed, Warren's health proposals are largely forgotten. What might have been is inevitably less compelling than what turned out to be. Paul Starr's major history of the U.S. health system devotes only a paragraph to Warren's efforts. And that reference occurs in the context of the later failure of President Harry Truman's push for a national plan (Starr 1982: 282–283). Indeed, the Truman failure in 1949 is commonly viewed as the turning point at which a public system ceased to be an option and private employer-provided health insurance became the *de facto* policy (Poen 1979). Yet Truman's health care foes had honed their political skills in the earlier battle with Warren. Also contributing to the neglect of the California experience is the perception that reformers were uninterested in the states as "health care laboratories" out of a perception that state officials were "inept, corrupt, or unprepared to tackle hard policy issues" (Sparer and Brown 1996: 182). This skepticism—it has been argued—continues to the present among policy researchers (Leichter 1997).

That the focus should be on Truman's failure, as opposed to Warren's, is also understandable in view of the general impression that the federal government was the dominant force in social policy after the 1930s. As Robert Rich and William White (1996: 13) put it, "the New Deal initiated a period in which the federal government was 'supreme,' and states were clearly in a subordinate position." However, the same authors note that with regard to health care the mid-1940s was a period of fluidity. Up to that point, there was little federal involvement in health care outside "exceptions" such as care for veterans, Native Americans, or other special groups (*ibid.*: 18).

Potential for a California Model

If Warren had succeeded in enacting a California health plan, would other states have followed? Might the later Truman effort have been devoted to fostering state plans rather than enacting a single national program? Might the United States, in short, have ended up with a system resembling Canada's provincially operated single-payer arrangements? There are some reasons to think this alternative sequence of events was a possibility.

First, when Warren's plan was put forward, there was no immediate prospect of a federal system being enacted. Nor was the employer-based private system anywhere as expansive as it became by the time the Truman plan was considered. There was—in short—a space for state expansion. As Thomas Anton (1989: 108) notes, “faced with situations that lack precedent, it makes sense for officials to find out what other jurisdictions have done.” There were no precedents for state-run health insurance systems of the type Warren proposed, so California could have provided one.

Second, California was a high-profile state by various indicators. Its population in the 1940s grew faster than that of any other state—in large part because of the expansion of military-related industries. In 1940, California was the third largest state; by 1950, its population was exceeded only by New York's. California's ports were the gateway to the Pacific Theater of World War II. Its Hollywood film industry attracted special attention to the state. Governor Warren himself was a national figure, declining the nomination as the Republican vice presidential candidate in 1944 but accepting it in 1948. In the *New York Times*, despite the large geographic distance between California and New York, attention to California-related issues tended to lead those of other states outside the *Times*'s tristate circulation area.¹ California was a state to watch.

Third, although much work has since been done on diffusion of state-level legislative innovations, California was identified as a high-innovation state in early research on that topic. Jack Walker (1969: 883) ranks California third among the forty-eight mainland states in his state innovation index. Virginia Gray's critique of Walker questions whether “innovativeness” could be viewed as an inherent state characteristic and argued for a case-by-case approach. Nonetheless, California came out as the top state in her overall ranking by order of adoption of various legislative innovations (Gray 1973: 1184). California was one of the early states to

1. *Times* coverage by state was measured by inches of space in the *New York Times Index* under each state's heading in 1945 and 1946. Generally, state coverage varied positively with population and negatively with distance from New York City. A few southern states received substantial coverage due to segregation-linked news. A simple cross-state regression explaining *Times* state coverage excluding the tristate circulation area of New York, New Jersey, and Connecticut is:

$$\text{INCHES} = 5.96^* + .07^{**} \text{POP} - .69^{**} \text{LOGDIST} + 5.04^* \text{CALDUM} + 10.51^{**} \text{SOUTHSEG}$$

(Adjusted $R^2 = .79$. *Significant at 5 percent level; **Significant at 1 percent level. $N = 45$. INCHES = sum of column inches devoted to text on a state in 1945 and 1946 in the *Index*; POP = residential population in 1945 in millions based on interpolation of the 1940 and 1950 censuses; LOGDIST = natural log of distance of state capital from New York City in miles; CALDUM = dummy for California; SOUTHSEG = dummy for Georgia, Mississippi, and Missouri. CALDUM varies in significance across different specifications.)

develop a network of limited-access highways (freeways) in the 1940s, a policy that did spread to other states, especially after the federal government provided resources for the interstate highway system. Warren's push for gasoline taxes to pay for such highway improvement was controversial and met with strong opposition from oil companies. But in that instance—unlike with health care—he succeeded in enacting his agenda. Warren, in short, was quite capable of being what Thomas Oliver and Pamela Paul-Shaheen (1997: 743–746) term a “policy entrepreneur.”

Fourth, although California was geographically distant from key Midwestern and Northeastern industrial states that might have been followers of a California plan, it is possible for innovations to escape regional boundaries. A key element in such expansion is whether the issues involved are “nationalized” (Mooney 2001: 119). Such nationalization can occur when there is federal encouragement for state action (Eyestone 1977: 442). Unemployment insurance—a state-administered system operated with federal tax support—is a good example. Of course, it is always possible that federal resources may come with such tight constraints as to discourage, rather than encourage, an innovation (Karch 2001: 28). However, there was congressional interest in fostering health insurance at the time the Warren proposals were put forward.

Fifth, there was diffusion of employer-based health insurance in the late 1940s when government (federal or state) failed to provide an alternative. Thanks to the precedent of wartime controls, tax incentives, and labor union policies, the die for employer-based insurance was cast by the time of Truman's health plan defeat. But that was not true when Warren made his initial proposals for California. Health insurance in some form was going to spread in the 1940s, but the form it would take was uncertain.

Absent government action in California or elsewhere, unions came to press for health coverage as an employer-provided private benefit. When unionized employers adopted health plans, many nonunion employers followed suit. Key figures in New York—including colorful Mayor Fiorello La Guardia—helped develop the privately run and financed alternative, thereby unintentionally reducing the scope for a government system. Thus, the major subsequent government extension into the health field involved nonworkers: Medicare for retirees, Medicaid for welfare recipients, and more recent benefits for children of the working poor. For employees, subsequent unsuccessful efforts from Richard Nixon to Bill Clinton were built on extending employer coverage, not a government-run single-payer system. And such job-based proposals ran quickly into the

problem of making a large number of diverse employer plans act as if they were part of a unified single-payer program.

Dewey and Warren or Dewey versus Warren?

In one way, Warren's proposal for state-run health insurance did enter the national arena. Warren turned down an invitation by Thomas Dewey to run as the Republican vice presidential candidate in 1944. He thought that running against Franklin Roosevelt in the midst of a war was a losing proposition, something that would not help his own presidential ambitions (Pollack 1979: 93). But when Dewey again offered the second slot to Warren in 1948, Warren accepted after being assured the vice presidential position would be elevated into an "assistant presidency" (Stone 1948: 153–167). The so-called dream-boat ticket, uniting two popular, centrist governors was seen as almost a sure thing, running against the accidental president, Harry Truman (Donaldson 1999: 155). The Truman administration, after all, was beset by strikes, inflation, a fractious Democratic Party, and a perilous international situation as the Cold War developed.

Dewey and Warren were similar in many ways. Both originated in small towns and stumbled into politics. Both had established their reputations as prosecutors, fighting crime and corruption. Dewey had prosecuted high-profile gangsters. Warren, notably, had pursued scams involving health insurance (really sickness insurance) policies (Ross 1935a: 217). Both had learned to moderate their positions to appeal to Democrats. Warren used California's cross-filing system to run in the Democratic and Republican primaries; in 1946 he won both nominations and went on to win his second term as governor. Dewey learned "fusion" politics firsthand in New York City and at times had a marriage of convenience with La Guardia, despite personal differences (Elliot 1983: 16, 221).

Both Warren and Dewey ultimately became three-term governors. And as governors both had many similar objectives, such as road construction, housing, and expansion of higher education. Indeed, the lives of the two seemed on parallel tracks; much later when Warren retired from the Supreme Court, President Nixon tried unsuccessfully to persuade Dewey to be his successor.

But there were also differences. Dewey was small and standoffish. Warren was large and gregarious. In 1948, however, there was one key issue on which they sharply disagreed: health insurance. Warren was for a state-provided system; Dewey was adamantly opposed to the idea. War-

ren's original plan, formulated in late 1944, proposed covering virtually all employees in California with state-run health insurance; an idea he saw as catering to the needs of returning GIs (Severn 1968: 109). Dewey in contrast favored private voluntary insurance.

Dewey was certainly familiar with the idea of state health insurance; Democrats in the New York State legislature began pushing it in the mid-1930s. Assemblyman Robert F. Wagner Jr., son and namesake of the (then) better known U.S. senator, was able to pass a bill to study the proposal for New York State in 1938, while his father agitated for a federal program (Huthmacher 1968: 264; Hirshfield 1970: 79–80). But although subsequent plans were submitted to the state legislature, Dewey found the budgetary cost to be sufficient reason to oppose them (Smith 1982: 453, 553).

As a candidate for president in 1944, Dewey wanted to appear moderate and discussed the health issue in very general terms while campaigning in California (Cray 1997: 165). But his opposition to state-run health insurance was solidified after a commission he appointed reinforced his fears of the costs entailed.² Of course, the split between Dewey and Warren gave Truman a campaign issue to which Republicans could not easily respond.³ Shortly before the Republican convention, Dewey denounced "politicians (who) want to relegate the business of curing sick people to the dead level of government mediocrity."⁴ And Warren defended his state health plan idea in a national magazine, decrying opponents who had used "ideological blackjack slogans" to defeat it (Warren 1948: 60).

Truman—who prior to 1948 had officially supported congressional efforts at national health insurance but had done little to assist them—came out strongly in support of the notion in the 1948 election campaign. That strategy meant, of course, that he would have to push for national health insurance the following year, should he win the election.

Precursors of Warren's Plan

As in other states, health care in California was long viewed as a private affair. Reformers in the early twentieth century who worried about issues

2. Dewey Board Split over Medical Care, *New York Times*, 16 February 1946.

3. Truman regarded California as a land of "crackpots" but had a warm regard for Warren, in part because of Warren's stance on issues such as health insurance. As governor, Warren was able to call on Truman to assist on a matter related to offshore gambling in California. Warren later returned the favor by serving as a trustee of the Truman presidential library. Weaver 1967: 138; Ferrell 1980: 128.

4. Dewey Attacks Medical Control, *New York Times*, 21 February 1948.

of adequate health care availability—often middle- and upper-class women—blended that question into a *mélange* of other concerns: birth control, health education, standards in public hospitals. Charity might be available to indigents needing medical services. But as targets of medical charity the poor competed with many other causes (Lothrop 1996: 361–410). Generally, those who could pay for health care did so on a direct fee-for-service basis to providers rather than through insurance.

A few employers in California, notably the influential Southern Pacific Railroad, did provide health services for workers. The Southern Pacific operated a company-run hospital for employees. Other employers had industrial doctors and nurses on staff in case of on-the-job injuries. By the late 1930s, the City of San Francisco had created a health insurance program, but for its municipal employees only (Starr 1982: 323). Thus, seeds of the idea of employer-provided health insurance were present before World War II.

California was innovative in deviating from the individual doctor/fee-for-service model. A clinic in Palo Alto operated a group practice in the 1920s. Prepaid “capitation” arrangements such as Ross-Loos (established in 1929) and later Kaiser Permanente (established in 1933)—essentially early HMOs—were created, but with considerable opposition from the medical establishment. Indeed, the founders of Ross-Loos were expelled from a local medical society for their transgression (Ross 1935b: 300; Starr 1982: 300–301, 322).⁵ As it turned out, the capitation model fitted nicely with the postwar union push for job-based health insurance, once the labor movement took up the drive to create such plans in the late 1940s. It was easier for unions to negotiate with employers about fixed payments to providers rather than open-ended, fee-for-service arrangements. Both sides of the negotiating table would know in advance what health expenditures would be during the life of their contract under the prepaid model.

There were also innovations in fee-for-service. While doctors did not like any insurance systems—fearing (correctly) that insurance providers would someday start negotiating prices—hospitals were less reticent. California’s Blue Cross plan goes back to 1932. The state’s Medical Society—with much internal opposition—created what became its Blue Shield plan, the California Physicians Service (CPS)—in 1939. CPS founder

5. The American Medical Association later reinstated the Ross-Loos founders after the state association had upheld the expulsion by its Los Angeles affiliate. Coast Group Medicine Gains, *New York Times*, 20 August 1939.

Ray Lyman Wilbur had actually supported an abortive 1918 attempt by referendum to create a state system in California (see below).⁶ Wilbur, later president of Stanford University, had been a Cabinet official in the Hoover administration. In that capacity, he had chaired a committee that produced a major report on national health needs in 1932, a report that supported voluntary insurance (Starr 1982: 296–307; Somers and Somers 1961: 318; Committee on the Costs of Medical Care 1932).

Indeed, there were doctors in California—some, such as Wilbur, in influential places—who looked with some sympathy at various proposals for universal, or at least expanded, health coverage. The 1918 California health insurance referendum episode in which Wilbur was involved was part of a national agitation in that period to follow the European example of government-supported health care (Hirshfield 1970: 13–17). In the mid-1930s, California's medical establishment flirted briefly with a state health plan. There was an attraction to physicians in widening the customer base and having bills automatically paid.⁷

Finally, California was one of the early states to adopt a Workers' (Workmen's) Compensation system, part of the progressive reforms initiated by Governor Hiram Johnson, a figure admired by Warren as a model politician. Although workers' compensation is more an income replacement plan than it is health insurance, it does have health aspects. And it was a precedent for state involvement in insurance to which advocates of state-run health insurance could later point. California's early enactment of workers' compensation showed the state's potential to be a source of other social reforms.

In 1918, as noted, there appeared on the California ballot a proposition to amend the state constitution to permit establishment of a health insurance plan. Although the national American Federation of Labor at the time opposed such proposals, the idea had many supporters among union leaders in California (Anderson 1968: 76–79).⁸ The insurance industry opposed the plan, however, because it included a death benefit that would have competed with the "industrial" life insurance policies then being sold commercially. Doctors were initially uncertain about the merits of a state-run plan but eventually opposed it, too, fearing government price

6. Wilbur's name can be found on an advertisement in support of the proposition in the *Los Angeles Times*, 3 November 1918.

7. Years later, Harry Truman wondered why doctors adamantly opposed his plan to subsidize use of their services. Ferrell 1980: 302–303.

8. Until the 1930s, the American Federation of Labor followed the doctrine of "voluntarism," distrusting governmental action. Programs such as health insurance or unemployment insurance should be left to private collective bargaining, according to this view.

controls. Because the idea of state insurance seemed similar to German social insurance, and since Germany was not a popular country in the World War I era, opponents tarred the California proposal as a Prussian plot to raise production costs in competing countries (Numbers 1982: 7). Faced with such opposition, the plan was overwhelmingly defeated by the California electorate and the idea lay dormant until the Great Depression.

Initially, New Deal planners of the federal Social Security system considered including a health insurance component. But the threat of doctor opposition led them to drop the proposal (Hirshfield 1970: 42–70). Nonetheless, interest in government-provided health insurance was rekindled and shifted to the state level when the Roosevelt administration gave up on it.

In California, the California Medical Association (CMA) House of Delegates deviated from the official posture of the American Medical Association and proposed a state-run plan for lower-income workers—under doctors' control, of course. A study by UCLA professor Paul A. Dodd (Dodd and Penrose 1939) had documented that lower-income Californians often could not afford health care and provided potential support for the doctors' plan. CMA's staff reported similar findings and noted that doctor incomes were being hurt by the Depression.

Acting in response to these reports in 1935, CMA—along with the state's dentists and nurses—pledged to cooperate with the legislature in creating a new plan (California Senate 1935: 83–85; CMA 1935a, 1935b). However, the honeymoon between doctors and state insurance was short-lived. Opponents of the idea within CMA soon forced a retreat. And reformers outside the CMA opposed control of any state plan by doctors. CMA returned quickly to a position of opposing a state-run system. But thereafter, whenever California doctors fought state health insurance, proponents would point to their one-time dalliance with the notion (Somers and Somers 1961: 318; Starr 1982: 272; Ross 1935a; Hirshfield 1970: 78).

California politics took a turn to the left with the election of Culbert Olson in 1938 as the first Democratic governor in decades. Olson had emerged out of the earlier unsuccessful 1934 "EPIC" campaign for governor by author Upton Sinclair.⁹ The state Democratic platform in 1938 included support for the implementation of state health insurance. Cali-

9. Sinclair's EPIC platform (for End Poverty in California) involved the takeover of Depression-idled factories and farms by the state, financed by some sort of new California currency. Although the EPIC campaign changed state politics by making the Democrats the majority party in California, Sinclair lost the 1934 election after a massive campaign to re-elect the incumbent Republican governor on the part of the business establishment.

ifornia health insurance advocates, such as philanthropist John Randolph Haynes, took heart from the platform pledge (Sitton 1999: 65–68). A group of faculty from the University of California-Berkeley, including physicist J. Robert Oppenheimer (later to head the Manhattan Project), formed to promote a state health plan. Olson appointed two members of the faculty group to help draft his proposal (Huntington 1971: 56–57). But in health care, as in many other aspects of state policy, Olson proved to be a weak and ineffective leader, especially in dealing with the legislature.

Olson unveiled a health insurance proposal in 1939, citing state workers' compensation and the more recent unemployment insurance system as precedents. His plan covered employees with incomes below \$3,000 a year (about 90 percent of the workforce) on a compulsory basis to avoid adverse selection. However, the self-employed were to be allowed to join voluntarily. Payments to doctors would be on a capitation basis to control costs. A tax totaling 3 percent of payroll, to be shared equally by employers, employees, and the state, would finance the program. The new governor proclaimed his plan to be "central" to his administration. Olson naively appeared to believe that because the health insurance idea appeared in the state Democratic platform, Democrats in the legislature would assuredly support it (Starr 1982: 306; Olson 1942: 15–20; Burke [1953] 1982: 177).

In fact, many Democrats in the state legislature were conservative, particularly in matters of government spending. The so-called Economy Bloc fretted about the cost and quickly came to oppose Olson's plan. At the time, proposals at the national level that would have provided a federal subsidy for state plans were going nowhere in Congress (Huthmacher 1968: 264).¹⁰ Had such federal funding been available, perhaps the cost to the state would have been less of an obstacle despite its Depression-era fiscal constraints.

But in any event, Olson's political persuasion skills were decidedly limited (Harris 1961: 6). When he sought to add the initial cost of the health plan to his budget proposal, opponents accused him of trying to "smuggle" the plan through the legislature. Yet California governors always submit budgets at the beginning of the calendar year and must include whatever expenditures they foresee. Ultimately, doctor and business opposition killed the Olson plan. The California Federation of Labor also

10. U.S. Senator Robert Wagner was the congressional proponent, but he could not obtain support from President Franklin Roosevelt. In a replay of the California experience in the World War I era, Senator Wagner believed that his German origins had helped kill the proposal.

opposed it, after some deals were cut (Burke [1953] 1982: 178). And a later attempt to reintroduce the plan by Governor Olson came to naught. However, the Olson proposal did provide a blueprint for Warren's staff in drawing up the initial Warren plan.

Development of the First Warren Plan

As state attorney general, Earl Warren feuded with Governor Olson on a variety of issues. Warren put together a powerful campaign against Olson in the 1942 gubernatorial election, attacking "Olsonism," pushing for the deportation of California's Japanese-origin population to inland camps, and forming an alliance with various elderly "pensionite" groups in the state that were then a powerful voting bloc (Mitchell 2000: 107–147).¹¹ Once elected, Warren had two advantages over the hapless Olson. Wartime prosperity had swelled state tax revenue, reducing budgetary concerns. And Warren was a more skilled politician than his predecessor. Despite his Republican credentials, Warren officially viewed the governorship as a bipartisan position. Thus, he always ran in the primaries of both parties and often appealed directly for public support for his programs from Democrats and Republicans.

World War II, by attracting new workers to California's booming military-related industries, began to change its demographic profile from an elderly state to the youth state it is today. Although Warren had used pensionite support to be elected, he looked for other programs that might appeal to younger voters and to returning military personnel. Health insurance seemed to him to be such a plan. Both young and old have medical bills.

Health insurance was again receiving an airing at the federal level as the war ended. Beginning in 1943, the first of a series of Wagner-Dingell-Murray bills was submitted to Congress. Unlike earlier proposals that would have subsidized state efforts, the new bills would have created a federally operated health insurance program. A Warren plan that put the responsibility at the state level might appeal, as an alternative, to conservatives opposed to more New Deal-type initiatives (White 1982: 109).

11. California's disproportionately elderly electorate was the source of various plans to provide government pensions to the aged. These included the Townsend Plan, a rival to Social Security at the federal level, and the "Ham and Eggs" movement for state pensions to be funded by a new California currency. The pensionite groups promoting these schemes felt betrayed by Olson. Warren was able to entice them by promising to put their representatives on a new state pension commission if elected.

And liberals might be drawn back to the older idea of federal support of state health programs, thus providing additional resources to state plans.

In his memoirs, Warren also cites concerns about sham health plans being foisted on a gullible public by private insurance companies and about families forced to do without adequate care during the Depression (Warren 1977: 177). There were rumors that apart from general policy issues, Warren was reacting to experience with high medical bills within his own family when he began to push for state health insurance. If so, it was unclear which family members were involved.

Given his feud with former Governor Olson, Warren never dwelled on the similarity of his eventual health proposal with that of his predecessor. Warren's memoirs refer to the brief flirtation of CMA with a state plan in 1935, but—remarkably—no mention is made there of the 1939 Olson proposal. Warren even manages to mention the formation of the voluntary CPS without making reference to Governor Olson; yet CMA's creation of the CPS was intended to respond to the Olson proposal by providing a voluntary, private alternative (ibid.: 177, 188).

Although not acknowledged by Warren in his memoirs, the fact is that Warren's staff used the old Olson bill as a starting point in working up his new proposal.¹² At the time the new plan was put forward, however, Warren indirectly acknowledged the Olson episode by pointing out that an earlier health plan had been defeated by the argument that the idea needed more study. So, the governor asserted, there was no need for yet more study in 1945 as the legislature debated his proposal.¹³

While Warren was more politically adroit than Olson, his level of what Californians would much later call "self-esteem" proved an obstacle to his health proposal. He assumed that the public would be on his side and would therefore pressure the legislature to do the right thing, Warren's thing. But public opinion was actually fluid on health matters. A 1943 CMA-sponsored poll found that about half the population supported "socialized" medicine. But it also found that support for a government plan fell sharply if a private alternative were offered (Starr 1982: 282). Warren made a major error—a deviation from his practice with regard to other agenda issues—in not conditioning public opinion before making his proposals. In the terminology of Oliver and Paul-Shaheen (1997: 747), he identified a "market opportunity," designed an innovation, but neglected the marketing.

12. Beach Vasey to legislative file, 27 December 1944, F3640:6093, Earl Warren Collection, California State Archives, Sacramento.

13. Governor Will Push Health Insurance Plan, *Sacramento Bee*, 10 January 1945, 1.

Still, there were some efforts, albeit inadequate in hindsight, to prepare a case for state insurance. The Warren staff gathered information on military draft rejection rates to show that many young men of conscription age were unhealthy.¹⁴ In addition, it was erroneously reported to Warren that Governor Dewey—his future running mate—was about to introduce a health plan in New York.¹⁵ Thus, momentum for creating state plans could be cited.

Warren had what many members of the legislature—including some in his own party—saw as an exclusive inner circle of advisers. In keeping with his “bipartisan” stance, these advisers and staff members might be either Republicans or Democrats. But given the controversial nature of a state health proposal, those outside the circle in the legislature would need to be persuaded. Warren, however, did not initially make an effort to prepare the legislature for his new plan (Johnson 1983: 69–71).

The lack of advance legislative involvement—although surprising in hindsight—was not out of keeping with Warren’s approach to other policy initiatives. He generally took a “hands off” approach to the legislature, instead relying on public opinion and consultations with interest groups. Warren would announce proposals after providing the public with persuasive background information through various channels. But he avoided cultivation of support with individual legislators outside the inner circle (Bernstein 1970: 120–123). Warren believed in compromise if it proved to be necessary. He hoped, however, that he could develop enough public pressure behind his proposals to move recalcitrant members of the legislature indirectly. Often, this public-first strategy worked. As noted above, Warren was able to impose a gasoline tax to begin the development of the California freeway system despite strong objections of the oil industry.

Public opinion often needs substantial preparation. In other policy matters, Warren set up citizen committees to study issues and to run public conferences to review alternatives before making his own proposal (Bell 1956: 247–279). For whatever reason, he did not follow this procedure with health care. Rather, he formulated a plan within his administration and then announced it. Thus, the first public airing of the issue of state health insurance under Warren came in the form of a specific proposal.¹⁶

14. Kenneth H. Leitch to Verne Scoggins, 18 December 1944, F3640:6071, Earl Warren Collection.

15. Helen MacGregor to Warren, 28 December 1944, F3640:6093, *ibid.*

16. Years later, neither Warren aide William Sweigert nor Assemblyman Albert Wollenberg (who acted as floor manager for the Warren bill) could explain why Warren did not use a conference or committee to develop public support for his health plan. Sweigert 1987: 81–82.

Once it was announced in concept, Warren took a personal role in the drafting of the details of the health plan, apparently not realizing that marketing was the more urgent priority. He stated in early January 1945 that developing these details would be his "main order of business." He claimed to be working until after midnight on the health proposal.¹⁷ Presidential ambitions may explain this hands-on approach to proposal design. Warren had already become a national figure, having turned down a run with Dewey as the Republican vice presidential candidate in 1944. Creation of a successful health insurance system in California could be a big asset in a possible 1948 Warren campaign for the presidency. Washington—officials in the Warren administration noted during the health insurance debate—was looking at the California proposal with interest.¹⁸

Warren recognized that doctors were likely to be the main opposition group. However, the governor felt he had good relations with CMA. He had let CMA officials recommend his director of the Department of Public Health, Dr. Wilton Halverson. To head off doctor opposition, Warren met with a group of key CMA officials in late 1944 and indicated that he would be formulating a state health plan. As it turned out, this personal contact did not mollify the doctors. Even the bare facts of the CMA-Warren meeting proved controversial.

One of the key meeting participants, Dr. John W. Cline (later president of the CMA) claimed that Warren promised that the officials would be able to discuss the new plan with the CMA's House of Delegates early in 1945. In the Cline version, no public announcement of the plan by Warren was to be made until after this discussion. Others in the Warren administration, however, dispute that account and viewed the meeting as simply a form of courtesy communication to an interest group.

Whatever did happen, the Warren plan was announced in late 1944—before the CMA delegates met. Many years later, Cline was still so incensed at Warren that he would not even acknowledge in an interview that the governor was physically a large man. (Warren was 6 feet tall and weighed 215 pounds.) Yet somehow Warren and his aides had the impression after the initial contact that CMA would not oppose his health plan (Earl Warren and Health Insurance 1971; The Governor and the Public 1973: 49; Sweigert 1987: 77). They quickly became aware of the doctor's likely resistance, however.¹⁹ When the CMA delegates finally met in early 1945, they opposed the already-announced Warren proposal.

17. Governor Will Push Health Insurance Plan, *Sacramento Bee*, 10 January 1945.

18. Warren Tax Bills Are Set for Hearing, *Sacramento Bee*, 7 March 1945, 1.

19. MacGregor to Warren, 29 December 1944, F3640:6093, Earl Warren Collection.

Halverson—Warren's director of public health—attended the CMA delegates meeting. He first thought the CMA might go for a study of alternative health plans with action on enactment delayed until 1946. But at most, the doctors would endorse an extension of unemployment insurance to cover hospitalization of the unemployed.²⁰ Warren, perhaps sensing the inevitable opposition, politely declined to attend the CMA delegates meeting.²¹

The angry Cline became a major CMA figure in managing the opposition campaign to the Warren plan. He hired the seasoned California political consulting firm Whitaker and Baxter (also known as Campaigns, Inc.) to handle the campaign against a state health plan. Clem Whitaker Sr. and Leone Baxter, a husband-and-wife team, had run the successful Republican gubernatorial campaign against Upton Sinclair's EPIC movement in 1934—and won. They were skilled at negative campaigning.

Personalities played a role. Whitaker and Baxter had worked for Earl Warren during his campaign for governor in 1942. But there had been a falling-out between Whitaker and Warren before the election. As a result, great enmity remained between them (Whitaker 1989: 48), and thus Whitaker was happy to lead the anti-Warren plan effort. But he advised Cline that the medical profession could not beat something with nothing. CPS, the CMA's voluntary (Blue Shield) insurance plan, needed to be expanded as a credible alternative to Warren's proposal.

California's business community reacted more slowly than the doctors. Initially, the state's Chamber of Commerce issued a rather neutral analysis of the Warren plan and other competing health bills (California State Chamber of Commerce 1945). But by late February, the state Chamber had opposed Warren's proposal—arguing that his plan would make California less competitive with other states by boosting payroll taxes.²² The local Los Angeles Chamber followed in opposition on 1 March (Los Angeles Chamber of Commerce 1945). Both groups argued that a state budget deficit would result from the plan.

Apart from doctor and business opposition, a rival bill was submitted by the Congress of Industrial Organizations (CIO), thus splitting labor union support for state health insurance.²³ At the time, unions were divided

20. CMA resolution of 6 January 1945, *ibid.* Such an extension of unemployment insurance would have conflicted with federal law, according to Warren administration staff. Vasey to Warren, 11 January 1945, *ibid.*

21. Warren to Philip Gilman, 3 January 1945, *ibid.*

22. State Chamber Hits Health Insurance, *Sacramento Bee*, 22 February 1945.

23. MacGregor to Warren, 2 January 1945, F3640:6093, Earl Warren Collection.

into two camps, the American Federation of Labor (AFL) and the more radical CIO. Warren's plan was based on fee-for-service reimbursement of medical services, probably because it was thought less likely to engender doctor opposition. After all, the doctors' own CPS was a fee-for-service arrangement. In contrast, doctors had shown their hostility to private capitation systems such as Ross-Loos and Kaiser. But the CIO wanted a capitation system—not fee-for-service—while the more conservative AFL supported the Warren plan.

The issue of fee-for-service versus capitation also raised a question for Kaiser and Ross-Loos. How would organizations that charged on a capitation basis fit into Warren's plan for fee for service?²⁴ Warren eventually asserted that his plan would somehow accommodate capitation systems.²⁵ But exactly how it would do so was unclear.

Finally, there were complaints from groups that felt left out of the Warren plan: chiropractors, visiting nurses, Christian Science healers, and optometrists.²⁶ Had Warren followed his earlier practice of public consultation before making a specific policy proposal, some of these concerns could have been handled. Or, at least, the scope of potential opposition would have been better known in advance.

Warren's plan (denoted AB 800 in the Assembly and SB 500 in the Senate) was to be financed by a 3 percent payroll tax. Half (1.5 percent) was to be paid by employers and the other half was to be paid by employees. Both employees and their dependents would be covered. A state authority would be created to administer the program. It, in turn, would be run by a ten-member board with the director of public health as an ex officio participant. There would be three employer representatives (with one a farmer), two from organized labor (presumably AFL and CIO representatives), one from government employees, three doctors, and a dentist. Plan coverage would extend to wage earners with annual pay between \$300 and \$4,000. Routine doctor services would be covered as would a variety of related services such as hospitalization and X-rays. Doctors could join or not join the plan; there would be no compulsion on the supply side. Those physicians that joined would—as noted above—be paid on a fee-for-service basis.

The competing CIO bill (AB 449) had a higher annual wage limit:

24. William T. Sweigert to Warren, 5 January 1945; Vasey to Warren, 1 March 1945 and 3 April 1945, *ibid.*

25. Warren Faces Political Crisis in Legislature, *Sacramento Bee*, 5 March 1945.

26. Vasey to Warren, 5 January 1945; Vasey to McGregor, 8 January 1945; Vasey to Warren, 26 February 1945; Geoffrey Davis to Warren, 6 March 1945, *ibid.*

\$5,000. CMA also submitted a bill (AB 1200)—again on the principle that you cannot fight something with nothing. Its bill proposed that workers receive cash sickness benefits from the unemployment compensation fund with incentives to enroll in voluntary plans, such as the CMA's own CPS.²⁷ Not to be outdone, the California Farm Bureau submitted two bills (SB 218 and 219) to increase access to county hospitals and to license voluntary plans through the Department of Public Health.

It was not until late January that the Warren administration seemed to realize that it needed a sharpened strategy to influence public opinion. A question-and-answer press release was then drafted.²⁸ The health proposal was said to be based on the same principle as government funding of the public schools. Favorable editorial comments on the Warren proposal were circulated. Individuals from the private sector who might be good spokespersons for the Warren plan were identified.²⁹ The CIO was asked to back the Warren bill and drop its proposal. But the CIO would not abandon capitation for the governor's fee-for-service approach.³⁰ To make matters worse for the prospects of the Warren bill, the CIO argued that the governor's proposal was not financially viable, precisely because it did not use capitation. By pushing that point, the CIO provided indirect support to other critics of the Warren plan who claimed it was fiscally unbalanced.

Defeat of the First Warren Plan

Eventually, it became evident to the Warren administration that a major campaign would be necessary to enact its proposal. Two radio programs were set up for late February 1945.³¹ In the first broadcast, the governor outlined the proposal, arguing that an insurance approach was appropriate for medical costs. His second radio address was more pointed, attacking the CMA's argument that the Warren plan would produce budget deficits and new taxes. Shortly thereafter, the Bureau of Public Administration at the University of California-Berkeley reported that the proposed 3 percent payroll tax would indeed provide adequate funding for both the Warren and the CIO plans (May 1945: 29). There were charges and countercharges on this point and on other issues.

27. As noted above, legal barriers were cited within the Warren administration to such use of unemployment compensation.

28. Sweigert to MacGregor, Scoggins, and Vasey, 30 January 1945, *ibid.*

29. Scoggins to Warren, 30 January 1945, *ibid.*

30. Vasey to Warren, 13 February 1945 (two memos), *ibid.*

31. Radio talk press releases, 21 and 28 February 1945, *ibid.*

Radio was not the sole province of the governor; CMA also used radio to attack the Warren proposal. Warren's radio addresses avoided mentioning the CIO bill. Probably, the governor did not want to give the rival plan publicity. But on their face, both plans were similar except for capitation, an issue that might have seemed arcane to the average radio listener. Thus, CMA referred to the Warren-CIO plan, as if they were one, hoping to tar Warren's proposal with the radicalism associated with the CIO (Harvey 1959: 230).

With television barely on the horizon, radio was a key battleground for political controversy. But newspapers were also very important. Whitaker and Baxter had developed a distribution network—the California Feature Service—that provided editorials on issues of the day. They used the network to offer editorials opposing the Warren plan to papers around California. Still, on the one hand, some important newspapers, such as the *Los Angeles Daily News* and the *Sacramento Bee*, supported Warren. On the other hand, the influential *Los Angeles Times* was strongly opposed to any state health insurance proposal.

Although both sides enlisted public opinion, ultimately the matter had to be fought out in the legislature. The Warren administration therefore sought to provide expert testimony to lawmakers that would support its proposed health plan. An obvious candidate was the previously mentioned Paul A. Dodd of UCLA, who had become active on health issues in the 1930s, particularly at the time of the abortive Olson proposal. Dodd and Ernest F. Penrose of the University of California–Berkeley had published a voluminous report on health conditions in California in 1939. However, Dodd and Penrose were not measured in their language, referring to opponents of a compulsory state system as “reactionaries” and calling for a state takeover of private hospitals. Moreover, they supported capitation, not fee-for-service. So Dodd and Penrose could not be good witnesses for Warren (Dodd and Penrose 1939: 430–431, 440).

Unfortunately, the key expert the Warren administration chose had a blemish. Dr. Nathan Sinai of the University of Michigan was indeed a well-known expert on health insurance. But his degrees were in veterinary medicine and public health. Thus, opponents ridiculed him as a “horse doctor” with expertise in “mosquito abatement” (Wollenberg 1981: 383; Sweigert 1987: 82). Opponents also sought to manufacture a scandal, questioning whether Sinai's travel expenses had been paid by state funds. In the end, poor Sinai was left plaintively asking, “What has all this to do with the validity of my testimony concerning this legislation?”³²

32. Expert Terms Health Plans Self Supporting, *Sacramento Bee*, 28 March 1945.

Opponents of the Warren plan initially argued that a two-thirds vote would be needed to pass it, a notion disputed by the administration.³³ As it turned out, there was no vote by either the full Assembly or the Senate on the actual plan. The Assembly's Public Health Committee on a 7-3 vote refused to send the Warren bill (and the CIO bill) to the house floor. The Republican floor leader at that point advised Warren to drop the issue or risk endangering other parts of his legislative agenda.³⁴

Warren refused to withdraw from the fray, and an attempt was made by friendly legislators to force health insurance to the floor. In an acrimonious debate, opponents noted that Warren's floor manager, Assemblyman Albert Wollenberg of San Francisco, had opposed the old Olson plan. Wollenberg replied that his thinking had "advanced" and that the Olson and Warren plans were not identical. But such defenses were not sufficient to save the proposal. The Assembly voted 39-38 against bringing the Warren plan to the floor (and 42-34 against bringing forward the CIO bill).³⁵ With the Assembly refusing to vote on the Warren plan, no action was taken in the Senate. The first Warren plan was dead.

The Second Warren Proposal

Warren remained determined and was affronted by the legislative tactics used to kill his proposal; the issue was now personal. So he came back with a second plan (AB 2201), this one a cutdown version of the original covering only hospitalization for employees and dependents. Since the new plan did not cover doctor bills, it was to be supported by a 2 percent payroll tax (instead of 3 percent under the old plan) split 50-50 between employer and employee. The tax base was to be the first \$5,000 in wages, and the plan would cover 30 days in the hospital. Generally, hospitals had been less resistant to experimentation than doctors; their early Blue Cross plans, for example, originated before the doctor-run Blue Shields came along. So Warren may have hoped for less opposition.

While it might seem that doctors would be unconcerned with a hospital-only plan, that was not to be the case. A hospital plan could be a foot in the door to a later plan covering doctors, something CMA feared (Harvey 1959: 237). Or—worse from the viewpoint of CMA—hospitals might start to offer (state-subsidized) medical services in competition with doctors.

33. Bourbon Chief Backs Health Insurance Idea, *ibid.*, 6 March 1945.

34. Warren Fights to Revive His Health Plan., *ibid.*, 4 April 1945.

35. Warren Health Bill Move Is Lost 39 to 38, *ibid.*, 11 April 1945.

With the same opposition groups denouncing the second Warren plan, events followed the fate of the first. The proposal was tabled 8–5 in the Assembly Public Health Committee, and an attempt was then made to force it to the floor. Warren called upon memories of the great flu epidemic after World War I to rally support. He argued that if such an epidemic were to reoccur now that World War II was drawing to a close, the state's population would face financial ruin.³⁶ Opponents complained that a governor should not “lobby” for his own legislative goals, a strange and remarkable proposition.³⁷ When the vote to bring the second Warren plan to the Assembly floor was called, the proposal failed by 45–32. For the balance of the 1945–1946 legislative session, there were no more health insurance proposals from the governor.

Warren's Catastrophic Health Insurance Plan

Voters did not hold Warren's actions on health insurance against him, quite the contrary. When he ran for re-election in 1946, he won the nominations of both the Republicans and Democrats in the primary. And with only minor party opposition, he was then re-elected overwhelmingly in November 1946. Armed with a strong public mandate from the voters, Warren thought he could finally prevail on health insurance in the next legislative session. Given the seeming mandate, he again did not set the stage with public forums or informal legislative consultations. In late 1946, he simply announced there would be a new health care proposal to be submitted to the legislature in early 1947.³⁸ A repeat of the 1945 scenario was thus set in motion.

The new plan was still less comprehensive than the second plan. It was to cover only major hospital expenses; that is, it was a “catastrophic” program. And, since job-based health insurance had started to spread in the postwar period, it had what today would be called a “play or pay” feature. Employers could provide a plan that met the minimum benefits of the state plan through private insurance. But if they did not, they would be compelled to join the state plan. The state plan—for those employers who chose to “pay” rather than play—would be supported by a 2 percent

36. Warren Blisters Opponents of His Hospital Bill, *ibid.*, 30 May 1945.

37. Legislators Set Adjournment for 16th of the Month, *ibid.*, 5 June 1945.

38. Warren Will Press for Broad State Health and Hospitalization Plans, *ibid.*, 28 December 1946.

payroll tax split evenly between employer and employee on the first \$3,000 of wages a year.

Despite these compromises—as compared to the first and second plans—Warren's third proposal was killed, this time in the Senate. The bill produced the same coalition of opposition from the medical and business communities that the earlier proposals had. Although one Senate committee reported favorably on the Warren bill (SB 788), the Committee on Governmental Efficiency tabled it with a 9–0 vote. The companion bill (AB 1500) remained bottled up in the Assembly Public Health Committee, which never voted on it after the Senate outcome.

With the third defeat, Warren changed his health focus to less controversial areas such as new hospital construction, a program that was eligible for federal subsidy. Mental health was another area targeted by Warren. Freudian ideas were by then being popularized. And Hollywood films, such as *Spellbound* (1945) and *The Snake Pit* (1949), which dealt with mental health issues, had attracted public attention. Whitaker and Baxter, their political reputations enhanced by the defeat of Warren's state initiatives, were recruited to battle Truman's health plan in 1949 at the national level.

The closest the state came to health insurance in the Warren era was adoption of a state disability plan for employees. Much later attempts at state health insurance in California were also to be unsuccessful, as noted below. Indeed, the only state to adopt and operate a plan—in this instance through an employer mandate—was Hawaii in the 1970s.³⁹ And the Hawaii plan in the 1970s did not have the demonstration effect for other states that a California plan in the mid-1940s might have had. Increasingly, the spread of employer-provided health insurance had taken the edge off proposals for government-run single payer health programs. Some of the credit or blame for that situation goes to Warren's 1948 running mate, Thomas Dewey, an opponent of state health insurance.

39. Massachusetts adopted a state health plan in the 1980s but repealed it before implementation. Hawaii had to obtain a special congressional dispensation from ERISA, the federal Employee Retirement Income Security Act of 1974 that regulates benefit programs, to implement its program. Massachusetts used a "play-or-pay" strategy in its never-implemented plan. A per-employee tax was imposed by Massachusetts from which employers could exempt themselves by providing health insurance to their workers. Other states in the late 1980s and early 1990s flirted with the idea of employer mandates but pulled back when implementation deadlines approached. See Oliver and Paul-Shaheen 1997 on the experiences of Massachusetts and other states.

Developments in New York

Given Dewey's adamant opposition, advocates of widespread health insurance in New York had to seek alternatives to a state-run plan. New York City accounted for over half of New York State's population in the 1940s. The city's mayor—the flamboyant Fiorello La Guardia—had presidential ambitions of his own; he resented Dewey's greater ability to pursue them. La Guardia, despite his nominally Republican affiliation, had close ties with organized labor. He was impressed with the ability of local apparel unions to provide health care for their members through private arrangements (Kessner 1989: 398–399, 462–470). But he also knew that for the vast majority of workers, such facilities were not available. As early as 1934, Mayor La Guardia unsuccessfully urged the local medical community to work out a group insurance system with the state legislature.⁴⁰

La Guardia supported national health insurance.⁴¹ But nothing like that was going to happen during World War II when military matters were the top priority. And with Congress shifting to the right, even an immediate postwar national plan was unlikely. Action at the New York State level was foreclosed by Dewey's opposition. Finally, La Guardia felt that the city could not afford to operate a plan for all of its residents.

Despite these constraints, a study by the city's municipal credit union outlining the financial problems faced by city workers when they became ill could be used for limited local action (Kessner 1989: 553–554). La Guardia used the report to create a committee to study a prepayment plan for city employees in 1943. In an echo of the reaction of California's doctors when the Olson plan was threatened, New York doctors then responded by setting up a Blue Shield-type plan to head off less palatable alternatives.⁴² Meanwhile, doctors appointed to La Guardia's committee pushed for a traditional fee for service approach within a plan limited to those of very low income. No committee consensus could be reached.

Given the deadlock, the mayor set up a new committee. With the aid of foundation loan support, the end result was creation of the private Health Insurance Plan (HIP). Among the members of HIP's original board was

40. La Guardia Urges Group Medicine, *New York Times*, 7 December 1934.

41. Referring to federal legislation to establish national health insurance when La Guardia announced the outlines of HIP, the mayor said, "Our hopes at the present time are based on enactment of the so-called 'Wagner-Murray-Dingell' bill" (Medical Care Plan, n.d.).

42. The New York version of Blue Shield was called United Medical Service. La Guardia wanted UMS to be folded into his own HIP plan—once it had been created—but the State Medical Society was not amenable to any such thing.

Henry J. Kaiser, whose firm had fostered Kaiser Permanente in California.⁴³ But unlike Kaiser Permanente, HIP did not own hospitals. And it did not directly employ doctors. Rather, it contracted for service on a capitation basis with groups of doctors for medical services. HIP required enrollees to choose a primary care physician to act as a “gatekeeper” in contemporary parlance, referring patients to specialists only when necessary (Jaskow 1953: 136–137). The HIP model thus had procedures that appear in today’s HMOs and managed care systems.

By the time HIP started operations in 1947 (after La Guardia was no longer mayor), it had 400 doctors under contract in 22 groups (Starr 1982: 322). For hospitalization, HIP was linked to Blue Cross. Although HIP was compulsory for city employees, an important feature was that other nonprofit employers were encouraged to join. And private employers, labor unions, and fraternal organizations could enroll.⁴⁴ Only individuals were excluded to avoid problems of adverse selection (Deardorff 1947: 157).⁴⁵

La Guardia’s HIP was thus differentiated from earlier plans for government employees. For example, as noted above, San Francisco City and County employees already had a plan. But that 1937 program was not open to other groups (Garbarino 1960: 206–207). In the same way, the Group Health Association of Washington, DC, was set up only for federal workers. Public policy in New York City, in contrast, had created a health plan that was built on a base of city workers but was aimed at attracting nongovernment groups. As his committee worked out the details of HIP, La Guardia hoped that his plan would somehow spark creation of a national program of comprehensive health insurance.⁴⁶ But inadvertently he had fostered something else: a private job-based alternative to a government-run plan.

Although HIP was originally based on city employees, its provisions permitting private and nonprofit employers to join eventually transformed it into a prototype of current practice. HIP’s early enrollees were found to

43. Kaiser apparently was asked to join instead of Wendell Willkie, the 1940 Republican presidential candidate (Prospectus, n.d.). Handwritten corrections on the document cross out Willkie and pencil in Kaiser.

44. Expansion of enrollees from the original base was slow. About 80 percent of HIP enrollees were still New York City municipal workers in 1950. Jaskow 1953: 184.

45. The HIP plan allowed employees elective coverage of dependents, which could have led to adverse selection. However, a minimum proportion of the employment group had to elect dependent coverage or it would not be provided to anyone in the group. HIP also allowed individuals who lost coverage because of a job change to buy individual policies, again raising the potential of adverse selection.

46. Health Insurance Plan Praised by Mayor, *New York Times*, 9 November 1944.

be more educated, more likely to be in professional and semi-professional occupations, and of higher income than the general New York City population. They were also less likely to be members of minority groups (Commonwealth Fund 1957: 21–28). This pattern can be observed today in the United States (and in California) and is characteristic of a job-based, voluntary system of health insurance.

With the defeat of the Warren plans, California was out of the running to create a model state plan that others might emulate. New York, the largest state in the country at the time and a center of liberal thought, might have been another state that could have led the nation down a road to state-run health insurance. But Dewey's opposition to any such thing diverted La Guardia and other potential supporters of government-run health insurance in another direction. Although Dewey did not defeat Truman in 1948, he may nonetheless have indirectly defeated Warren's hope for state-level single-payer health insurance. An alternative direction in New York would have helped Warren in California. As noted, when his first health plan was being formulated, Warren was erroneously told that Dewey was supporting a plan in New York. For that matter, a victory for Warren in California might have eased Dewey's opposition in New York, perhaps leading figures such as La Guardia to move for a California-type plan—rather than HIP—in New York.

What if?

With hindsight, history tends to look like a logical flow of events. Forces can be identified that seem to explain the sequence. What happened appears inevitable. There is a tendency to forget that every regression model purporting to “explain” observed behavior contains an error term reflecting a margin of uncertainty.

So was the evolution of U.S. health insurance as an employer-based system with less than universal coverage preordained? Clearly, a state plan for California did not appear to be a hopeless cause to Earl Warren in the mid-1940s. He would not have invested political capital in trying to enact one if the task appeared impossible to accomplish. And Warren's record in other aspects of California politics showed him to be an astute politician. But his general astuteness failed him in the case of health care when he neglected to develop and cultivate public support for the general concept of state insurance.

Suppose Warren had done a better job in promoting his plan—the kind of job he did in overcoming oil company opposition to taxes for highway

development. Suppose Warren's health plan had been enacted in California before the great growth in private union plans occurred. A success by Warren in California might have sparked liberals in other states to push to emulate the California example. Unions—seeing hope for state plans—might have moved more slowly in negotiating private alternatives. Dewey might have been less vocal in his opposition to a state plan in New York. HIP might not have developed as it did. Truman might have pushed for enactment of federal support for state plans rather than a federally run system. The web of interest groups that promoted "Harry and Louise" TV ads to kill the Clinton health plan might never have developed. Within firms, especially large firms, a group of personnel executives whose status depended on running costly health plans might not have come into existence (Martin 2000: 173). Instead, the United States might have moved toward a system similar in broad terms to what exists today in neighboring Canada. By the same token, defeat of Warren's health plans may have discouraged politicians in other states from proposing similar programs.

What might have happened is, of course, ultimately speculation. The possibility of an alternative sequence of events cannot be proved. But the California experience at least provides a plausible scenario for a different outcome. And it suggests that the turning point in U.S. health care history may well have come before defeat of the Truman proposal and that its location may well have been Sacramento in 1945–1947, not Washington, DC, in 1949.

Nonetheless, California today has an above-average rate of uninsured persons in its population. Its county emergency rooms have become the de facto health care providers of last resort for indigents. Even if there had been no emulation effect elsewhere, a success by Warren in California would have led to a different contemporary picture.

An Echo of the Past in California

Since Warren's era, attempts have been made periodically in California to interest the electorate or the legislature in a state health plan. None of these has been successful. But two noteworthy examples appeared on the state ballot in the 1990s.

The first, Proposition 166, was placed on the ballot with the backing of the CMA. Just as the CMA flirted with a state-run, but doctor-controlled, health insurance fund in the mid-1930s, CMA sought to create a doctor-controlled employer mandate plan in 1992. Under its Affordable

Basic Care (ABC) Initiative, employer-provided health insurance would have been required. But state entities would also have been created that would have constrained the managed care practices that have become the nemesis of physicians.

Liberal groups opposed the doctors' proposal in 1935 over the issue of doctor control and did so again in the case of Prop 166. Opponents to Prop 166 included the state AFL-CIO, the California Nurses Association, and Consumers Union. They combined their opposition with that of conservative business and taxpayer groups. The electoral success of U.S. Senate candidate Harris Wofford on a health care platform in Pennsylvania in 1991 may have suggested to CMA that health care would be a winning proposition in 1992. It certainly was a factor in candidate Clinton's espousal of a national health system in the presidential election (Peterson 1998: 187). Nonetheless, Prop 166 was defeated with a 68 percent vote for no. In yet another replay of history, the enemies of the Clinton plan imported the services of California consultants who had helped defeat Prop 166, just as the opponents of Truman had imported Whitaker and Baxter in 1949 (Johnson and Broder 1997: 203).

The subsequent Proposition 186 was a true throwback to the Warren era. When the Clinton plan was defeated at the national level in 1994, advocates of universal health coverage proposed a state-run single-payer system for California. The notion that those who forget—or more probably are ignorant of—history repeat it received much support in this episode. At least Warren did not have to deal with firmly ensconced job-based health insurance when he first made his proposal in 1944–1945. But the proponents of Prop 186 assuredly did. The proposition went down to crushing defeat with 73 percent of the voters opposed, about the same margin that defeated the “German” notion of state insurance in California in 1918. Remarkably, the supporters of Proposition 186 later portrayed their massive electoral loss as a valuable learning experience (Farey and Lingappa 1996).

Conclusion

In 1887, Edward Bellamy wrote the prophetic novel *Looking Backward* in which a utopian America of 2000 is depicted. Among the wonders he envisioned was a universal health care program available through a kind of credit card system (Bellamy [1887] 1917: 121–122). It did not quite work out that way. But it might have—had Earl Warren succeeded in enacting his health plan in California and had other states followed the

California example. The American system of voluntary employer-paid health insurance with less than universal coverage seems to many observers today to be an inevitable product of the balance of forces that were in play after World War II. Much effort has been devoted to trying to explain why the seemingly similar United States and Canada inexorably make different social policy choices. But perhaps the U.S.-Canada divergence in the area of health insurance was not as inevitable as contemporary observers suppose.

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